COMMENTARY

Pneumonia, friend of the elderly

Must we rescue everyone we can? Should our ability to do something work against us, at times obliging us to act against our better judgment? We can cure even elderly, demented people of pneumonia, but not everyone will consider this a morally compelling argument for doing so.

In the decades since we learned to treat pneumonia, the life expectancy in western nations has increased significantly. More and more elderly people will come down with pneumonia in the years to come. How should we think of pneumonia, in the elderly or anyone else? There is good reason to think of pneumonia as a blessing in some cases, specifically in elderly, demented persons.

This is not the place to argue for the morality of this perspective. The article by van der Steen and colleagues begins from the reasonable premise that pneumonia may signal a welcome way out of suffering. Their article will do nothing to change the mind of anyone who insists we must always work to cure elderly persons of pneumonia. It will, however, offer useful guidance to families of elderly, demented nursing-home patients and the physicians who treat such patients.

The very idea of a checklist rests on the notion that decisions should be made on the basis of persons, who will naturally differ in circumstances, as opposed to principles, which by definition do not vary. The checklist seeks to guide caretakers of incompetent patients to make arduous decisions about both curative and palliative care. The checklist responds to the absence of an advance directive or "living will." Relatively few Americans have prepared such documents: many do not know about them whereas others avoid thinking about them. Even if we do prepare advance directives, physicians do not always honor them. Presumably any physician who would agree to withhold treatment from an elderly, demented patient would also

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agree to honor an advance directive requesting this be done. The advance directive would make this decision easier for all concerned.

The most important benefit of this checklist from the Netherlands is to help break up a complex question into more manageable segments. Faced with a difficult decision, many of us will respond in the same way as the daughter in case 1—we may feel morally compelled to do everything possible for a demented parent in a nursing home. On further reflection, specifically on the questions brought out by the checklist, we may feel more reluctant than compelled. This is progress.

Beyond guiding our deliberation in an enormously trying moment, the checklist serves a broader purpose. It gives us permission to think in concrete terms about the quality of someone else's life. The checklist facilitates the enormously difficult task of deciding for others. It allows us to consider whether pneumonia may be a blessing instead of a burden.

This checklist returns us to a familiar debate over the morality of withholding and withdrawing medical treatment. Most primary care physicians and bioethicists in the United States will likely embrace this checklist as a useful and welcome resource.